APPLICATION/UPDATE FOR MEMBERSHIP
SOUTH CAROLINA SOCIETY OF PLASTIC SURGEONS

Application For_____Active Membership (In practice in SC more than 12 months)
_____Associate Membership (In practice in SC less than 12 months)

Today's Date _____

FULL NAME:_____
Date of Birth:_____
_____
Nick Name:_____
Spouse's Name: _____
_____
Children's Names/Ages:_____
_____
OfficeAddress:_____
_____
Phone#:_____**Fax#**_____
Home Address:_____
_____
Phone#:_____**Email**:_____

EDUCATION: LOCATION DEGREE YEAR
Undergraduate College:_____
_____
Medical School:_____
Other Graduate School:_____
_____

HOSPITAL: LOCATION FROM TO
Internship: _____
_____
General Surgery Residency:_____
_____
Plastic Surgery Residency:_____
_____
Other Residency:
Type:_____**Where**_____
Fellowships:
Type:_____**Where**_____
Type:_____**Where**_____
_____
Honors:_____
_____
_____
_____

APPLICATION/UPDATE FOR MEMBERSHIP
SOUTH CAROLINA SOCIETY OF PLASTIC SURGEONS (cont.)

MEMBERSHIP IN OTHER ORGANIZATIONS: (Include office held)_____
_____
_____
_____
HOBBIES:_____
_____

SC MEDICAL LICENSE#:_____
BOARD ELIGIBLE IN PLASTIC SURGERY?_____
BOARD CERTIFIED IN PLASTIC SURGERY?_____**CERTIFICATE#**:_____
DATE:_____
OTHER BOARD CERTIFICATION:_____

Have you ever had your hospital privileges revoked or suspended? _____
Have you ever had your state medical license revoked or suspended?_____
Have you ever had your state or federal narcotics license revoked or suspended?_____
If yes, please attach a note of explanation.

I began the practice of Plastic Surgery in South Carolina:
Month:_____**Year:**_____

I approve the following listing to be placed on the SCSPS web site representing myself and practice of Plastic Surgery. I am a Member or Candidate Member of the ASPS.

Name:_____
Business: _____
Address:_____
_____
Phone:_____
Web Site:_____

Personal information to only be utilized by SCSPS and not posted on the web:

E-mail address for notifications by SCSPS:_____
Preferred Telephone # for notifications by SCSPS:_____

I verify that the above stated information is true, and if it is ever found that I have misrepresented the above information, my membership in the SC Society of Plastic Surgeons may be terminated.

Signature:_____
Date:_____

Note:

1. **Attach a copy of your Curriculum Vitae and a Photograph.**
2. **Yearly Dues of the SC Society of Plastic Surgeons is $100. Please attach payment. Prompt payment of dues is expected upon approval of membership. No SCSPS Member will be listed on the SCSPS Website without their permission and membership dues paid in full.**
3. **When completed please send to:**

Gary Culbertson, MD, FACS
2845 Lillington Dr.
Sumter, SC 29150
803-773-6361
803-773-6361 (fax)
www.garyculbertson.com
garyculb18@gmail.com

DO NOT WRITE BELOW THISLINE

Executive Council Action:____Approved____Disapproved (Date:_____)
Membership Approved:_____Associate Member (Date:_____)
Active Member (Date:_____)